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NORTHERN REGIONAL MEDICAL COMMAND
INSPECTOR GENERAL

Inspection of Facilities Used to House Warriors in Transition

Period of Inspection
9 April 2012 – 31 August 2012

[redacted]

DEPARTMENT OF THE ARMY
HEADQUARTERS, NORTHERN REGIONAL MEDICAL COMMAND
9275 DOERR ROAD
FORT BELVOIR, VIRGINIA 22060-2204

REPLY TO
ATTENTION OF

MCAT-CG 2 October 2012

MEMORANDUM FOR The Surgeon General/Commanding General, U.S. Army Medical Command

SUBJECT**:** Inspection of Facilities Used to House Warriors in Transition (FY 12)

1. I approve the findings and recommendations in the enclosed Inspector General report on the "Inspection of Facilities Used to House Warriors in Transition for FY 12."

2. Upon receipt of Department of Army Inspector General and The Surgeon General / Commanding General USA MEDCOM concurrence, I authorize its immediate release to the organizations listed below and on the Northern Regional Medical Command's internet web pages.

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CF**:** (w/encls)
Congressional Defense Committees
Assistant Secretary of Defense for Health Affairs
Department of Defense Agencies
Secretary of the Army
Installation Management Command
MEDCOM/OTSG OneStaff

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DEPARTMENT OF THE ARMY
HEADQUARTERS, NORTHERN REGIONAL MEDICAL COMMAND
9275 DOERR ROAD
FORT BELVOIR, VIRGINIA 22060-2204

REPLY TO
ATTENTION OF

MCAT-IG 2 October 2012

MEMORANDUM FOR Commander, Northern Regional Medical Command (NRMC)

SUBJECT**:** Final Report on the Special Inspection of Facilities Used to House Warriors in Transition

1. Purpose. Obtain the NRMC Commander's signature on the enclosed Special Inspection of Armed Forces Housing Facilities Used to House Warriors in Transition.

2. Discussion. On 16 February 2012, the NRMC Commander directed the "Inspection of Facilities Used to House Warriors in Transition."

3. The inspection teams identified 36 findings and 6 observations and made recommendations for corrective actions related to the objective. A summary of findings and observations are included in chapter 3.

4. The Summarized Findings are presented in the Executive Summary.

5. Recommendation. That the RMC Commander**:**

a. Approve the final report.

b. Authorize its immediate release to The Surgeon General, Congressional Defense Committees, Assistant Secretary of Defense for Health Affairs, Department of Defense Agencies, Secretary of the Army, Installation Management Command, MEDCOM/OTSG OneStaff and posting on the NRMC Command's internet web pages.

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Executive Summary

1. **Background.** On 18 September 2007, the Deputy Secretary of Defense (DEPSECDEF) promulgated standards for facilities housing Warriors in Transition (WTs) who are receiving outpatient medical care. These standards focus on the areas of assignment, baseline accommodations, and special medical requirements. On 28 January 2008, Public Law 110-181, Sec 1662 was enacted requiring the Regional Medical Command (RMC) Inspectors General (IGs) to conduct semi-annual inspections of all WT housing semi-annually for the first two years and annually thereafter; to submit a report on each facility inspected to the post commander, the Secretary of the Military Department concerned, the Assistant Secretary of Defense for Health Affairs, and the Congressional Defense Committees; and to post the final inspection report on their respective Internet Website. To facilitate the conduct of the inspections, Headquarters, Department of the Army, issued guidance via ALARACT 162/2008 on 3 July 2008 to all Army activities. This message directed US Army Medical Command (MEDCOM) RMC IGs, in coordination with Installation Management Command (IMCOM), to oversee the inspection effort. It also provided the RMC IGs authorization to task staff members and IGs assigned to Senior Commanders and IMCOM as well as "unlimited access to Army activities, organizations, and all information sources necessary to complete the inspection". On 31 January 2012, the Commanding General, US Army Medical Command directed Commanders of Regional Medical Commands to issue a directive to their IGs to conduct "Inspections of Facilities Used to House Warriors in Transition." On 16 February 2012, the RMC CG issued the directive to the Command Inspector General to conduct "Inspections of Facilities Used to House Warriors in Transition." On 1 December 2011, the term "Warriors in Transition" (WTs), was re-termed as "Soldiers". Soldiers in Transition (STs) was the common terminology used to address Soldiers in this program.

2. **Purpose.** The purpose of the inspection was to evaluate the adequacy of facilities used to house Warriors in Transition.

3. **Concept**. That the Northern Regional Medical Command (NRMC) IG, leading a team of IMCOM and Senior Mission Command Inspectors General and augmented with Subject-matter-experts, conduct the inspection of the Warrior in Transition facilities located at nine (9) installations within the NRMC region.

4. **Objective.** Determine if facilities used to house Warriors in Transition are in compliance with Memorandum, Deputy Secretary of Defense, 18 September 2007, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

5. **Summary of Findings, Observations, and Recommendations.**

a. Based on the objective above, three sub-objectives were used to determine compliance. The sub-objectives are**:** Assignment, Baseline Standards and Special Medical Requirements. All findings stated in Chapter 3 below were based on the DEPSECDEF Memorandum as the source document. Additional standards were included as necessary. For the purpose of this report, findings with an asterisk indicate an Electrical, Life, and Fire Safety finding. These findings

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were immediately reported to the respective WTU leaderships and/or the appropriate installation agencies for corrective action. In the report, quantitative terms, such as "few, some, majority, most and all" are used to describe percentile ranges linked to specific findings or observations. These terms are defined as follows**:**

Few	1-25%
Some	26-50%
Majority	51-75%
Most	76-99%
All	100%

b. The inspection teams determined that some of the Warrior in Transition Units (WTUs) in the region were in compliance with the DoD Housing Inspection Standards for Medical Hold and Holdover Personnel. Overall, the inspection teams determined that recovering service members were assigned to housing facilities that best meet their needs. Most recovering service members were satisfied with the daily operations within their WTUs. As well, the Warriors in Transition (WTs) were also satisfied with their respective Installations' support in addressing their privatized housing concerns. Additionally, the Installation Management Commands' (IMCOM), Directorates of Public Works (DPWs), in coordination with the privatized housing agencies, consistently responded to WTs with housing issues through prompt resolution of service requests (work orders). Most WTs were given the appropriate priority level for service requests in accordance with (IAW) the housing inspection standards. The inspection teams found that throughout the region, this priority service did not negatively impact the Installations' ability to resolve work order requests for the balance of their populations. Largely, the barracks and housing maintenance teams at each installation were competent and efficient in resolving issues once identified.

c. The inspection team inspected 2146 areas which were comprised of living spaces, laundry rooms, utility rooms, mechanical rooms, multi-purpose rooms and storage rooms. The inspection teams determined the following throughout the region**:** 1) that <u>most</u> of the WTUs were in compliance with Assignment; 2) a <u>few</u> were in compliance with Baseline Standards; and 3) that the <u>majority</u> were in compliance with Special Medical Requirements, IAW the DEPSECDEF guidance as indicated above. The minor deficiencies identified throughout the region were usually corrected on the spot or within 24 hours of submission of the work order. Leaders at all levels of the commands continuously searched for ways to improve or upgrade the facilities and furnishings in order to enhance the quality of life and further enhance the healing process.

d. The inspection teams recognized a notable degree of consideration was used when selecting furnishings, flooring, neutral colors, and patterns free from complex geometrical shapes or designs. This was particularly relevant to WTs with cognitive and/or visual limitations or those who may be experiencing Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), or other behavioral health issues associated with PTSD.

e. During the period of the inspection, the region had an average population of 2133 WTs. The inspection team leaders utilized interviews as an information-gathering method and interviewed approximately 20% of the WT population. The inspection team also interviewed the WTU Commanders, First Sergeants, platoon sergeants, squad leaders and Family members. Overall, the

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leadership in each unit demonstrated an understanding of the standards, policies, and guidelines which applied to the WT program. Most of the WTs interviewed commented that their medical needs were being addressed appropriately and that they were receiving quality medical care. Most WTs were aware of and actively participating in their Comprehensive Transition Plans (CTP).

f. In summary, using quantatative terms, few of the WTU facilities within the region were in compliance with Memorandum, DEPSECDEF, 18 September 2007, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel. The inspection teams made recommendations to the respective WTU leadership and the Senior Installation Commanders or their representatives in an effort to assign responsibilities to correct deficiencies identified during the inspections. All of the recommendations were received in a cooperative manner.

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Chapter 1 Objective and Methodology

1. **Objective**. Determine if facilities used to house Warriors in Transition are in compliance with Memorandum, Deputy Secretary of Defense, 18 September 2007, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

2. **Inspection Team**. The inspection teams consisted of at a minimum**:** 1) IG Team Leader; 2) Installation IG Coordinator; 3) DPW Subject-matter-expert (SME); 4) Safety SME; 5) Information Management (IM) SME; 6) privatized housing representative; 7) Medical personnel and/or Nurse Case Managers; and 8) WTU leadership/escorts.

3. **Methodology**.

a. **Observation.** The inspection teams inspected the following types of Warrior in Transition occupied facilities**:** DoD Owned Unaccompanied Personnel Housing (UPH), DoD Lodging (Appropriated/Non Appropriated), Leased/Contracted Housing and Lodging, Privatized Housing and Lodging. Assessment of Privatized Family Housing was conducted with the consent of the occupant and in coordination with the privatized housing management partner. All family housing on the inspected installations were managed by a privatized housing partner. The inspection team did not inspect any DoD Owned Family housing.

b. **Document Review.** The inspection teams reviewed the following documents as part of the inspections process**:** 1) Work Order requests; 2) WTU policy memorandums; 3) guidance specific to WTUs; 4) Installation/local policies and Standard Operating Procedures (SOPs).

c. **Interviews.** The inspection teams conducted interviews with the WTU Commanders, First Sergeants, Platoon Sergeants, other cadre/staff members, WTs and Family members.

4. **Locations Visited:**

a. Fort Belvoir, VA

b. Fort Bragg, NC

c. Fort Dix, NJ

d. Fort Drum, NY

e. Fort Eustis, VA

f. Fort Knox, KY

g. Fort Meade, MD

h. Walter Reed National Military Medical Center, MD

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i. West Point, NY

5. **Findings/Observation Format**.

a. Where a violation of a published standard, policy, law or regulation existed, a Finding Statement was developed and is addressed in the following format**:**

Finding statement
Standard(s)
Root Cause
Discussion
Recommendation

b. Where there was no violation of a published standard, policy, law, or regulation, but an observation was made to improve current operations, an Observation Statement was developed and is addressed in the following format**:**

Observation statement
Standard(s), if applicable
Discussion
Recommendation

6. In the report, quantitative terms, such as "few, some, majority, most and all" are used to describe percentile ranges linked to specific findings or observations. These terms are defined as follows**:**

Few	1-25%
Some	26-50%
Majority	51-75%
Most	76-99%
All	100%

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Chapter 2 Good News

1. At one installation, a Fisher House was specifically designed to mitigate cognitive disabilities for Warriors that suffer from PTSD and TBI. This included the elimination of complex geometric patterns on floors and walls that cause WTs to become disorientated. A subtle texture or pattern was used to help WTs with depth perception.

2. A WT at one installation credited the Fire Department with saving his life.

3. At most installations, the WTs and their Families were very pleased with privatized housing and their prompt reaction to work orders.

4. Most WTs were very pleased and made positive comments about rooms in new barracks facilities.

5. One installation had a designated parking garage; an excellent addition to the WTB complex.

6. One installation had an excellent mail room operation that provided a critical and valuable service to the Soldiers.

7. At one installation a WT Family received a loaner washer/dryer (delivered within 1 hour).

8. One WTB purchased portable AC units to provide to WTs during HVAC outages.

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Chapter 3 Findings and Observations

NOTE: All findings stated below were based on the DEPSECDEF Memorandum as the source document. Additional standards were included as necessary. For the purpose of this report, findings with an asterisk indicate an Electrical, Life, and Fire Safety finding. These findings were immediately reported to the respective WTU leaderships and/or the appropriate installation agencies for corrective action.

Objective: Determine if facilities used to house Warriors in Transition are in compliance with Memorandum, Deputy Secretary of Defense, 18 September 2007, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

FINDINGS

Finding 1.1*: A few installations did not have fire evacuation plans posted to indicate means of primary/secondary egress.

Standards: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject: DoD Housing Inspection Standards for Medical Hold and Holdover Personnel / Local SOP and local fire and safety regulations / National Fire Protection Association (NFPA) 101 Life Safety Code 29.7.4.1 (Emergency Plans).

Root Cause: Don't Know. WTU lacked the knowledge to recognize the requirement.

Discussion: The inspection teams determined that fire evacuation plans were not posted on room doors, hallways and near the exit signs. Fire evacuation plans are required to provide evacuation information to WTs and their visitors on safe passage from the building. The inspection teams determined that the WTU leadership believed the illuminated exit signs were sufficient, however, the inspection teams determined the fire evacuation plans must be posted IAW the NFPA Code above.

Recommendations: The inspection teams recommended the fire evacuations plans be posted in each room, the hallways and the exit signs IAW NFPA Code above.

Finding 1.2*: Faulty Ground Fault Circuit Interrupters (GFCI) were found at most installations.

Standard: 29 CFR 1910.304, Occupational Safety & Health Administration required GFCIs when the outlet is installed near a water source.

Root Cause: Don't Know. The WTU leadership were not aware of the inoperable GFCIs or details of the standard.

Discussion: The GFCIs were not installed according to standard and were inoperable and did not protect a user from electrical shock as designed. Additionally, even a working GFCI on a faulty outlet could still produce an electrical shock, thus creating a potential safety hazard.

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Recommendations: The inspection teams recommended the WTU leadership work with the facility engineers and submit work orders to ensure the GFCIs are repaired and properly installed.

Finding 1.3: At one installation, the square footage for WTs in UPH did not meet the minimum standards.

Standards: Memorandum, Assistant Chief of Staff for Installation Management (IMCOM), 14 October 2009, Subject**:** Unaccompanied Personnel Housing (UPH) for Warriors in Transition; Army Regulation (AR) 420-1, Army Facilities Management, 12 Feb 08.

Root Cause: Won't Comply. The leadership decided not to move WTs due to the pending move to the new facility.

Discussion: As a result of a command decision, Soldiers were assigned two per room, which resulted in the WTs having less than the 90 Square Feet (SF) minimum space as required by the standard. The team observed vacant rooms which presented the opportunity to relocate WTs and provide the minimum square footage by the standard. This is a repeat finding.

Recommendations: The inspection team recommended the chain of command utilize vacant rooms and relocate the effected Soldiers to provide the minimum required square footage. The inspection team also recommended that privatized or off post housing be considered as additional alternatives.

Finding 1.4*: A few installations had missing and inoperable smoke detectors in Unaccompanied Personnel Housing, Privatized Housing Units and Leased/Contracted Lodging.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: Don't Know. The inspection teams did not find consistent indicators that the smoke detectors were being inspected as required by the installation safety/fire station personnel or by the unit leadership (company cadre).

Discussion: Throughout the region, the inspection teams identified smoke detectors which were inoperable. Some were missing batteries while others appeared to have been purposefully disconnected from a hard-wired system. Some WTs commented that they reported to their WTU leadership, that their smoke detectors intermittently "beeped" or "chirped" and then removed the units when no action was taken. Particularly, WTs with behavioral health concerns found the beeping annoying. The inspection teams also determined that smoke detectors were not interconnected and would not alert other rooms in the event of an emergency. Further, the inspection teams determined that a majority of the smoke detectors in WTU facilities and privatized housing required batteries. Batteries were installed the same day by maintenance representatives from the DPWs and the privatized housing agencies.

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Recommendations: The inspection teams recommended the WTU leadership and maintenance/safety/fire station personnel periodically check all the smoke detectors during routine inspections and submit work orders immediately as appropriate.

Finding 1.5: At a few installations, unauthorized ammunition and weapons were found.

Standard: AR 190-11, Physical Security of Arms, Ammunition, and Explosives, 15 Nov 06

Root Cause: Don't Know. The WTU leadership was unaware the WTs possessed the items.

Discussion: The inspection teams determined that WTs had unauthorized ammunition and weapons (i.e. brass knuckles and switch blades) in their rooms. The possession of the unauthorized items were in violation of local and WTU policies and presented an unsafe environment for the WTs and their visitors. Due to the seriousness of these issues, the WTU leadership at those locations were immediately contacted and corrective actions were taken to remove the items.

Recommendations: The inspection teams recommended the WTU leadership reeducate the WTs on the prohibitions in the installation and barracks SOP and continue to enforce the standards. The inspections teams also recommended that the WTU leadership check for prohibited items during their routine inspections.

Finding 1.6: At a majority of the installations, the UPH facilities had inoperable and missing handicap access buttons.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: Won't Comply. The WTU and installation leadership did not find it cost-effective to obligate funds for the repairs.

Discussion: At one installation, the WTU and installation leadership were aware of the inoperable access buttons, but did not find it cost-effective to obligate funds for the repairs since the WTs were not complaining and maneuvered in and out of the buildings. At one installation, the access button adjacent to a parking area was inoperable, requiring the WTs to traverse around the entire building to gain access. At other installations, deficiencies included the removal of the support bar between the doors (which made the buttons inoperable), delays in work order submissions as well as delays in corrective actions.

Recommendation: The inspection teams recommended that the WTU leadership submit work orders immediately to repair or install the access entry buttons.

Finding 1.7*: At a few installations, mold was observed.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

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Root Cause: Don't Know. The low occupancy rate in the UPH resulted in a lack of oversight and the WTU leadership was unaware of the mold issues due to lack of regular routine inspections.

Discussion: Mold was observed throughout the inspected buildings (HVAC vents, windowsills, sinks, showers and refrigerators). The inspection team determined the mold had the potential to present an unhealthy environment for the Soldiers and that appropriate measures were necessary to rid the facilities of the mold issue.

Recommendations: The inspection team recommended that work orders be submitted and leaders at all levels ensure appropriate measures are taken to resolve the mold issues. The inspection team recommended that robust inspection procedures be implemented to prohibit future recurrences. The inspection team further recommended that the leadership to contact their local Industrial Hygiene agencies for an assessment and determination of the type of mold.

Finding 1.8*: A <u>few</u> installations had leaking and inoperable sprinkler systems.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: (Won't Comply). At one installation, the leadership determined that it was not cost-effective to repair the sprinkler system. (Don't Know). The leadership at other WTUs recognized the requirement, but lacked the experience and knowledge to correct the problems. Additionally, they relied upon the fire department's expertise to inspect and correct the deficiencies as necessary.

Discussion: The inspection teams determined that the sprinkler systems posed a fire safety hazard. In one Lodging Facility, the sprinkler system had been inoperable for the last two years. The lodging facility was scheduled for demolition therefore no funds were allocated to replace or otherwise repair the systems. At another installation, the inspection team determined that sprinkler heads caps were not removed and some were installed improperly which would cause the units to not operate properly. This is a repeat finding.

Recommendations: The inspection teams recommended that the WTU leadership, with the assistance of their local fire departments, submit a priority one work order for immediate corrective action. The teams also recommended periodic checks of all sprinkler systems during routine inspections or WT Cadre visits, and submit work orders as necessary.

Finding 1.9: At <u>some</u> installations, stained mattresses were observed.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

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Root Cause: (Don't Know). The WTU leadership did not check (forgot) the mattresses during routine inspections. (Can't Comply). At other installations, the WTU leadership lacked the resources to purchase covers and mattresses.

Discussion: The inspection teams determined that the mattresses did not have covers to prevent them from staining. Some of the stains appeared to be from body fluids and some of the stains were from dirt.

Recommendation: The inspection teams recommended the WTU leadership replace the stained mattresses and purchase covers to prevent stains and keep them serviceable. The inspection teams also recommended that the leadership to contact their local Industrial Hygiene agencies regarding the stains which appeared to be from body fluids. The WTU leadership stated they would take immediate action to resolve these issues.

Finding 1.10: At a <u>few</u> installations, WTs were not able to adequately control the temperature of their housing units.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: Can't Comply. The seasonal change of the HVAC system was the responsibility of the respective installations and not the WTU leadership.

Discussion: This is a recurring deficiency as new WTs rotate into the WTUs. The installations' policies to change the HVAC system is determined by their local standard operating procedures and based upon a specific time of the year, and not the actual temperature outside. These system changes normally occur in the spring and the fall. During periods of unseasonably warm or cold weather, WTs were unable to adequately control their HVAC systems.

Recommendations: The inspection team recommended that in the future, the WTU leadership provide either portable air conditioning units or heaters during these transition periods as needed. The team also recommended that the WTU leadership work with their local installation leadership regarding the HVAC requirements for the WTU facilities as stated in the DEPSECDEF guidance.

Finding 1.11: A <u>few</u> installations had a malfunctioning and or inoperable HVAC system**.**

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: Don't Know. The WTU leadership and DPWs did not regularly check the HVAC systems. There was no indication that routine inspections were being accomplished.

Discussion: The inspection teams determined there were malfunctioning and inoperable HVAC systems during the review of work orders submitted by the WTU and by direct observation. The inspection teams determined the malfunctioning/inoperability of the HVAC systems were

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attributed to the extreme changes in weather conditions and/or a lack of proper periodic maintenance.

Recommendations: The inspection teams recommended that the WTU leadership and DPWs check the HVAC systems during routine inspections or WT Cadre visits, and submit work orders immediately for repairs.

Finding 1.12*: At a few installations, flammable liquids and liquid containers were found in UPH and parking garage.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: Don't Know. The WTU leadership did not know the flammable liquids and containers were stored in prohibited areas.

Discussion: This is a recurring deficiency as new WTs rotate into the WTUs. Corrective actions for this finding is the direct responsibility of the WTU Cadre during their routine inspections. Flammable or combustible liquids must be kept in flammable liquid storage cabinets or in detached buildings. This finding is also a violation of local SOPs and fire safety regulations. In each instance of a finding, an on the spot correction was made and the WTU leadership removed the hazard.

Recommendation: The inspection teams recommended that the WTU leadership remove the hazards immediately and provide training to subordinate leadership. Additionally, the inspection teams recommended that the WTU leadership continue to reinforce the standard throughout their organizations and perform periodic checks during routine inspections.

Finding 1.13*: Unapproved electrical extension cords, power strips (without surge protectors), and multi-plug outlets were found in UPH on most installations.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: Can't Comply. The WTU leadership has a challenge in controlling and applying the standard due to the ongoing turnover of WTs.

Discussion: The only authorized electrical extension cord is one that is UL listed. Extension cords are for temporary use and not designed to be used long term. Power strips must have surge protector capabilities. Multi-plug outlets are not authorized for use in the UPH. Additionally, the leadership cannot prevent the private purchase of these items by the WTs at commercial stores to include the Post or Base Exchanges (PX/BX). Based on the opinion of the Subject matter experts, the use of these items has the potential to create a fire hazard. The inspection teams determined that this is an ongoing challenge for the leadership to correct. This is a recurring deficiency as new WTs rotate into the WTUs.

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Recommendation: The inspection teams recommended that the WTU leadership continue to teach and train the WTs and enforce safety standards as appropriate to avoid hazards.

Finding 1.14: At a <u>few</u> installations, UPH rooms did not have hot water.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel

Root Cause: Don't Know. The WTU leadership did not check for hot water during routine inspections nor did they follow-up on work orders provided to the installation.

Discussion: The inspection teams turned on faucets in the rooms and determined that there was no hot water. This was later confirmed through interviews with the WTs. At one installation, the DPW stated it was an ongoing problem for the building and that it was being corrected by the contractor. At another installation, the water was turned off by the DPW in order to correct the hot water issue.

Recommendations: The inspection teams recommended the chains of command and DPWs work closely with the contractor to immediately correct the issue. The inspection teams also recommended the chains of command check for hot water during routine room inspections.

Finding 1.15: At <u>some</u> of the installations, the fire doors in the UPH did not function properly.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel

Root Cause: Don't Know. The WTU leadership were unaware of the malfunctioning fire doors or the details of the standard.

Discussion: The inspection teams observed doors that did not automatically close as designed. The teams determined that some of the doors were improperly cut and others needed to be adjusted. Fire doors must close and latch automatically. Additionally, some of the fire rating plates on the doors were painted and obstructed the information. The plates specifically stated that they are not to be removed or covered.

Recommendations: The inspection teams recommended that the WTU leadership and DPW maintenance personnel periodically check all doors during routine inspections. The inspection teams also recommended the WTU leadership submit work orders immediately or as necessary to correct the issues.

Finding 1.16: At a <u>few</u> installations, the inspection certificates were missing from the elevators.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

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Root Cause: Don't Know. The WTU leadership were not aware of the requirement to post either the certificates or the notice in the elevators.

Discussion: The inspection teams discovered the annual inspection certificates, which indicated the elevators were inspected and operating properly, were missing from elevators in the WTU facilities. In lieu of the certificates, the units could have placed a notice in the elevator that designated the location of the inspection certificates. These were also missing.

Recommendations: The inspection teams recommended that the certificates and the notices designating the location of the certificates be posted immediately. The teams also recommended that the WTU leadership check the elevators during routine inspections.

Finding 1.17: At a <u>few</u> installations, Assignment and Special Medical Requirements for a few WTs were not being met in privatized housing.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: Won't Comply. The leadership did not clearly enforce or require the WTs to move, even when there was potential for aggravation of the injuries.

Discussion: WTs are assigned to privatized housing based on their medical conditions. These medical conditions change over time and thus the assignment and special medical requirements also change. The inspection teams determined that a few of the WTs did not want to move to a different residence for personal reasons (i.e. friendships and family). In most cases, the WTU leadership deferred to the desires of the WT.

Recommendations: The inspection teams recommended that the WTU leadership continue to work with the Triad of Care and enforce the standard based on the most current evaluation of the medical condition.

Finding 1.18*: At a <u>few</u> installations, hot plates, toaster ovens, "George Foreman" grills, candles, and electrical heaters were found in WT rooms.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel / Local SOP and local fire and safety regulations.

Root Cause: Won't Comply. Local policies were not properly enforced.

Discussion: This is a recurring finding. Most installations established local policies which prohibited hotplates, toaster ovens, "George Foreman" grills, similar cooking appliances and electrical heaters. The inspection teams discovered a few prohibited cooking appliances were being used by WTs in their rooms. The teams determined that the local policies were not properly enforced. Open flames present a clear danger and are strictly prohibited in the UPH. In each case, the unit leadership was notified and corrective actions were taken.

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Recommendation: The inspection teams recommended that the WTU leadership routinely check for and enforce the standards for prohibited cooking appliances, electrical heaters and candles during routine inspections or WT Cadre visits.

Finding 1.19*: A few installations had ceiling penetration openings in the janitors' and utility closets.

Standards: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel / Local SOP and local fire and safety regulations / NFPA 101 Code 8.6.2.

Root Cause: Don't Know. The WTU leadership were unaware of the penetration openings in the janitors' and utility closets nor were they aware of the details of the standards.

Discussion: The janitors' and utility closets had openings around the pipes in the ceiling that presented a life and fire safety hazard. These openings would allow a fire to spread from one area or floor to another, causing additional damage and threat to life.

Recommendations: The inspection teams recommended the WTU leadership submit appropriate work orders to seal the openings around the pipes. The inspection teams also recommended that the WTU leadership inspect the closets during routine inspections.

Finding 1.20: A few installations had rooms with missing and/or inoperable TVs**.**

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: Don't Know. The WTU leadership did not check for missing and inoperable TVs during routine inspections.

Discussion: The inspection teams determined that some rooms at the WTU facilities had missing and inoperable TVs. In majority of the cases, these rooms were vacant and not being routinely checked by the cadre. The inspection teams also found inoperable TVs in a few occupied rooms however, those WTs were not present for inquiry.

Recommendation: The inspection teams recommended that during their routine inspections, the WTU leadership check to ensure TVs are physically present in the rooms and working properly.

Finding 1.21*: At a few installations, the inspection and maintenance of fire extinguishers was not being performed.

Standards: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel / Local SOP, local fire and safety regulations, NFPA 25 Code 5.2.1.1.1, NFPA 72 Code 10.1.1.

[redacted]

[redacted]

Root Cause: Don't Know. The WTU fire marshals were not trained and lacked the experience to identify and perform the requirement.

Discussion: The inspection teams determined that routine inspections and maintenance of fire extinguishers was not being conducted. Although, the WTUs had appointed unit fire marshals, they were not trained and several months had lapsed without inspections. The inspection teams also determined that a few of the fire extinguishers needed to be replaced.

Recommendations: The inspection teams recommended that the WTU leadership in conjunction with their local fire departments, replace the fire extinguishers which were out of compliance. The inspection teams also recommended that the WTU chain of command contacts the local fire department to get the unit fire marshals trained.

Finding 1.22*: At a <u>few</u> installations, stacked clothing and boxes on wall lockers prohibited an 18 inch clearance from the sprinkler heads.

Standards: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel / Local SOP and local fire and safety regulations / NFPA 13 (18 Inch Sprinkler Clearance).

Root Cause: Don't Know. The WTU leadership were unaware of the standard.

Discussion: The inspection teams determined that stacked clothing and boxes on wall lockers prohibited an 18 inch clearance from the sprinkler heads. Blockage of the sprinkler heads creates a life and fire safety hazard.

Recommendation: The inspection teams recommended the stacked items be removed to ensure compliance with the standard. Additionally, the teams recommended that the WTU leadership check to ensure as new WTs move into the facility, this standard is not violated. This is a repeat finding.

Finding 1.23: A <u>few</u> installations had cracks in the walls and the ceilings.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: Won't Comply. The installation leadership made a conscious decision to not comply until an assessment was completed to determine the damages, actions and resources required for repair.

Discussion: The inspection teams determined that rooms in the WTU facilities had cracks in the walls and ceilings that may have been caused by a minor earthquake in 2011. The local DPW stated that assessments to determine damages and repairs were currently ongoing. At one WTU facility, the cost of the repairs is the responsibility of the installation. However, at other installations, funding for repairs was not an issue since the buildings were under warranty.

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[redacted]

Recommendation: The inspection teams recommended that the WTU leadership provide DPW maintenance the appropriate work orders and continue follow-up until the repairs are completed.

Finding 1.24*: A few installations had inoperable emergency lights in the stairwells.

Standards: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel / Local SOP and local fire and safety regulations / NFPA 101, Code 7.10.1.2.1.

Root Cause: Don't Know. The WTU leadership were not aware of the requirement to check the emergency exit lights.

Discussion: The inspection teams determined that the emergency exit lights in the stairwells at a few installations were inoperable. The inspection teams also determined the standard that applied was not known to WTU leadership. By all indications, the WTU leadership assumed that the fire departments would have been responsible for the requirement.

Recommendation: The inspection teams recommended the WTU leadership submit work orders to get the emergency exit lights repaired due to the life and fire safety hazard it presented to the WTU facilities.

Finding 1.25: One installation had an inoperable elevator in the parking garage.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: Don't Know. The WTU leadership were not aware and did not check the elevator during routine inspections.

Discussion: The inspection team determined that the parking garage elevator was inoperable in the WTU facility. The inspection team determined the inoperable elevator was unknown to WTU leadership and was not an item checked during routine inspections. An elevator is very important to a WTU facility because it can move WTs with mobility issues safely between floors or decks of a building or other structures. The parking garage elevator provides protection; overhead coverage and avoids subjecting WTs from unnecessarily entering harsh increment weather. Because of the wheel chair access laws, elevators are a legal requirement in new multi-story building, especially where wheelchair ramps would be impractical.

Recommendation: The inspection teams recommended the WTU leadership expedite submission of a work order to the installation DPW to have the elevator repaired.

Finding 1.26: At one installation, rooms were missing laundry equipment and telephones.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel

Root Cause: Can't Comply. The contractor has not provided the missing equipment.

[redacted]

[redacted]

Discussion: The inspections teams determined a few rooms in the WTU facility were missing laundry equipment and telephones. The inspection teams also determined the missing equipment from the rooms was attributed to back order issues experienced by the contractor.

Recommendation: The inspection teams recommended the WTU leadership continue follow-ups with DPW to ensure the contractor requisition and expedite the installment of the equipment.

Finding 1.27: At a <u>few</u> installations, the dining facilities in the WTU compounds did not have handicap accessible doors.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel

Root Cause: Don't Know. WTU and installation leadership failed to recognize the requirement during the initial planning and construction phases.

Discussion: The inspection teams determined that the dining facilities did not have handicap accessible doors making it extremely difficult for Solders with mobility issues or in wheel chairs to gain entrance or egress. The inspection teams determined that work orders were not submitted to install the handicap accessible doors. Two new WTU complexes did not have handicap access buttons installed at their dining facilities.

Recommendation: The inspection teams recommended the WTU leadership immediately submit work orders and continue to follow-up with their DPWs until the doors were installed.

Finding 1.28: At <u>one</u> installation, the grounds and landscaping did not present an attractive appearance.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

Root Cause: Can't Comply. The necessary resources were not available to fund the grounds and landscaping contract.

Discussion: The inspections team determined that IAW the DEPSECDEF guidance, the WTU grounds and landscaping shall be well maintained, provide an attractive appearance and be litter free. The team determined that a contract did not exist to provide grounds maintenance. The leadership determined that it would not be feasible for the WTs to conduct the maintenance based on the myriad of medical conditions, limitations and profiles. The cadre's responsibility is to take care of the WTs. The leadership further determined that a marked decrease in WT care would occur if the cadres' missions included grounds maintenance. The matter was a funding issue. The installation did not have the necessary resources in place to maintain the grounds and landscaping contract.

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[redacted]

Recommendation: The inspection teams recommended the WTU leadership contact the installation leadership to re-establish the grounds and landscaping contract.

Finding 1.29: A few installations had missing and/or damaged window screens.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel

Root Cause: Don't Know. The WTU leadership did not check window screens during routine inspections.

Discussion: The inspection teams determined that a few WTUs had missing and/or damaged window screens. Checking for the screens was not part of a routine inspection by the leadership.

Recommendations: The inspection teams recommended that the WTU leadership submit work orders and conduct follow-up actions until the window screens are repaired or replaced. The inspection teams also recommended that the WTU leadership check for damaged or missing screens during their routine inspections.

Finding 1.30: At a few installations, the shower curtains were dirty and mildewed.

Standard: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel

Root Cause: Don't Know. WTU leadership did not check shower curtains during routine inspections.

Discussion: The inspection teams found dirty and mildewed shower curtains in the WTU facilities. These presented an unhealthy environment for the WTs. Most of the shower curtains became mildewed because of the length of the curtains in conjunction with the positioning of the shower rods. A combination of long curtains hung on poorly positioned rods added to the issue.

Recommendations: The inspection teams recommended the WTU leadership check for mildew and improperly hung curtains and replace them. Additionally, the teams recommended they add this item to their routine inspections.

Finding 1.31: At one installation, the wrong fire alarm strobe was mounted on the wall.

Standards: Memorandum, Deputy Secretary of Defense, 18 Sep 07, Subject**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel / NFPA.

Root Cause: (Don't Know). WTU lacked the knowledge to recognize the requirement.

Discussion: The fire department SME determined that a fire alarm strobe mounted on the wall was actually designed for the ceiling. The SME further determined that the ceiling unit would need to be replaced with a unit designed for the wall.

[redacted]

[redacted]

Recommendations: The inspection team recommended the WTU leadership take immediate action to have the fire alarm strobes mounted correctly. Also, the inspection team recommended the WTU leadership coordinate with the local fire department to ensure the unit is operating properly and perform periodic inspections IAW the applicable standard.

OBSERVATIONS

Observation 1.1: At a few installations, unsecured medications were found.

Standard: Local SOPs required medications be locked in safes provided in each room.

Discussion: The inspection teams found unsecured medications in the WTs' rooms in the UPH. In some cases, where WTs were present, on the spot corrections were made. It is vital that medications be placed in locked safes and out of reach of children and other visitors that may enter the WTU facility. There was no consistent standard on the issuance of safes. Some WTUs did not have safes. Additionally, the inspection teams did not find a standard which applied to securing medications. A "best practices" position was used as the standard guidance.

Recommendations: The inspection teams recommended that the WTU leadership continue to check for unsecured medications and apply their best practices as part of their routine inspections.

Observation 1.2: At some installations, the rooms were too cluttered.

Standard: Local UPH SOPs.

Discussion: The inspection teams determined there were cluttered conditions in some rooms. WTs acquire additional personal items, souvenirs, items from charities, donations, etc, and over a period of time, their rooms become cluttered. The inspection teams determined that cluttered rooms have the potential to create a unsafe environment. A lack of adequate storage space at the majority of the locations was the primary contributing factor.

Recommendation: The inspection teams recommended that the WTU leadership consider providing temporary storage facilities to eliminate the cluttered environment for WTs.

Observation 1.3: At one installation, the defibrillator alarms were inoperable.

Standard: Local Installation / UPH SOPs.

Discussion: The inspections teams determined the defibrillator cabinet doors had alarms that were inoperable due to dead batteries. The batteries were replaced in those units which needed them. Some of the units required additional maintenance beyond battery replacement.

Recommendation: The inspection teams recommended the WTU leadership check all the defibrillators during their routine inspections. The inspection teams also recommended the WTU

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leadership contact the local fire department to determine if additional training is required for the unit fire marshals.

Observation 1.4: At one installation, the WT Soldiers complained of foxes.

Standard: Local Installation / UPH SOPs.

Discussion: WTs in the UPH complained about the number of wild foxes around their facility. They were concerned the animals could be carriers of rabies. The Installation CG was aware of the issue and directed his DPW to address and resolve the matter.

Recommendation: The inspection teams recommended the installation leadership implement measures to control the fox population on the installation.

Observation 1.5: Personally Identifiable Information (PII) and Protected Health Information (PHI) were unsecured.

Standard: Privacy Act / Health Insurance Portability and Accountability Act (HIPAA)

Discussion: The inspection teams found unsecured and unprotected PII and PHI information in the WTU facilities. The PII and PHI information was found on desk tops, beds, and other visible areas. The inspection teams determined that the unprotected PII (SSNs, credit cards, bank statements, etc.) and PHI (treatment records, medical history, etc.) information Subjected WTs to possible personal identity theft and compromised the protection of their private information. In each instance, the teams notified the appropriate Privacy Officer for inquiry and resolution.

Recommendation: The inspection teams recommended that PII and PHI be properly secured. Also, the inspection teams recommended the WTU leadership check for unsecured PII and PHI information during their routine inspections.

Observation 1.6: At one installation, there was improper disposal of syringes.

Standard: MEDCOM Reg 40-35.

Discussion: The inspection teams determined some WTs did not have the appropriate "Sharps" containers in their UPH rooms for disposal of used syringes. Used syringes not disposed of in the appropriate containers presented a safety health hazard for WTs and their visitors. WTs must have an appropriate container to store and dispose of used syringes to prohibit the possible reuse and redistribution by other personnel.

Recommendation: The inspection teams recommended the WTU leadership ensure the WTs are issued the appropriate Sharps containers. The inspection teams also recommended that the WTU leadership contact a trained and appointed official to routinely inspect and dispose of used syringes according to local policies and applicable regulatory guidance.

[redacted]

Appendix 1 Directive

DEPARTMENT OF THE ARMY
NORTHERN REGIONAL MEDICAL COMMAND
9275 DOERR ROAD
FORT BELVOIR, VA 22060

REPLY TO ATTENTION OF

MCAT-CG

16 February 2012

MEMORANDUM FOR Northern Regional Medical Command Inspector General

SUBJECT: Directive for Inspection of Facilities Used to House Warriors in Transition

1. You are directed to oversee and conduct a special inspection of the facilities used to house Warriors in Transition. This inspection will conclude no later than 1 September 2012.

2. The inspection will focus on the following objective: Determine if facilities used to house Warriors in Transition are in compliance with Memorandum, Deputy Secretary of Defense, 18 September 2007, subject: DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

3. You are authorized to task staff members, Inspectors General assigned to Senior Mission Commanders and IMCOM, and are to have unlimited access to Army Activities, organizations, and all information sources to ensure the successful and timely completion of this inspection requirement.

4. You will provide me with a mid-course progress review on or about 1 June 2012, followed by a written report not later than 20 September 2012

5. Point of contact is Mr. James C. Draine at commercial (571) 231-5392 or DSN 289.

JOSEPH CARAVALHO, JR.
Brigadier General, MC
Commanding

4 Encls
1. MEDCOM Directive
2. Public Law 110-181, 28 JAN 08
3. ALARACT 162/2008, 3 JUL 08
4. ALARACT 295/2008, 9 DEC 08

[redacted]

[redacted]

Appendix 2 Detailed Standards List

DEPUTY SECRETARY OF DEFENSE
101 0 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

SEP 18 2007

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
UNDER SECRETARY OF DEFENSE FOR PERSONNEL
AND READINESS
UNDER SECRETARY OF DEFENSE FOR
ACQUISITION, TECHNOLOGY AND LOGISTICS
ASSISTANT SECRETARY OF DEFENSE FOR HEALTH
AFFAIRS

SUBJECT**:** DoD Housing Inspection Standards for Medical Hold and Holdover Personnel
The Wounded, Ill and Injured Senior Oversight Committee (WII-SOC), a joint DoD/DVA committee, met and approved the following policy changes on August 28, 2007.
Effective immediately, the Military Services will provide housing for medical hold and holdover personnel in accordance with the attached standards. These standards address baseline accommodations and special features and services that may be required depending on a member's medical condition and treatment plan. The Secretaries of the Military Departments are directed to use these standards for conducting the inspections required by section 3307 of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (Public Law 110-28), and to report inspection findings to the Under Secretary of Defense for Personnel and Readiness not later than October 31, 2007. Timely implementation of these standards is a top Department priority.
Attachment**:**
As stated
HOUSING INSPECTION STANDARDS FOR MEDICAL HOLD AND HOLDOVER PERSONNEL

1. **PURPOSE**
These standards shall be used as a basis for evaluating the adequacy of facilities that house medical hold and holdover personnel.

2. **GENERAL**
In general, medical hold and holdover personnel receiving outpatient medical treatment (hereafter referred to as MH personnel or MH members) shall be assigned or referred to housing that exceeds or meets the applicable quality standards and is appropriate for their medical condition, expected duration of treatment, dependency status (including authorization of a non-medical attendant), and pay grade. The particular housing and associated amenities/services

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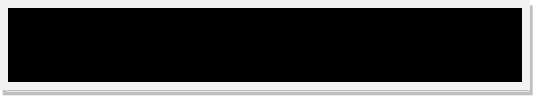

provided shall be an integral part of their medical treatment plan as determined by the primary care physician, patient, and chain of command. Note that some MH personnel with serious medical conditions are authorized non-medical attendants at the discretion of their primary care physician to assist in their recovery and rehabilitation. Non-medical attendants can include the member's parent, guardian, or another adult (18 or over).

3. **APPLICABILITY**

These standards address baseline accommodations, and any special medically needed facility features and services. Standards and guidance are also provided for associated furnishings, amenities, operations/services, and maintenance that are critical to well being and morale. These standards apply to the following types of housing when occupied by MH personnel**:** DoD-owned family housing (FH), DoD-owned unaccompanied personnel housing (UPH), Lodging owned by DoD, whether supported by appropriated funds or a non- appropriated funded instrumentality (NAFI). Lodging types include temporary duty (TDY) lodging, permanent change of station (PCS) lodging, recreational lodging, and military treatment facilities (MTF) lodging, e.g., Fisher Houses. Leased/contracted housing and lodging, to the maximum extent permitted by the associated agreement. Privatized housing and lodging, to the maximum extent permitted by the associated agreement. Note these standards do not apply to a service member's privately-owned home, or a rented home in the community (not privatized) that a service member obtains on his or her own.

4. **PRIORITY FOR SERIOUS MEDICAL CONDITIONS AS A DIRECT RESULT OF ARMED CONFLICT**

It is fitting those medical hold personnel who have "serious physical disabilities" or that are the "direct result of armed conflict have priority for housing and certain services. While the minimum housing standards are the same for all medical hold personnel, DoD has a special obligation to provide the best for seriously Wounded Warriors. Examples where priority should be considered include**:** housing waiting lists, furnishings and electronic equipment, parking spaces, time to respond to maintenance requests, etc. Furthermore, the housing status of these seriously Wounded Warriors should be monitored at the Service HQ level.

5. **RESPONSIBILITIES**

The chain of command shall be responsible, in consultation with the patient and the patient's medical support team and case managers, to validate that every MH member is adequately housed in accordance with these standards. Before a MH member is assigned/referred to housing (e.g., before transitioning from inpatient to outpatient status), the case manager shall provide consultation to the chain of command to ensure that the intended patient housing meets any special medical needs. If an assigned/referred housing unit for a member does not meet all the applicable standards in this document, the installation or garrison commander shall document the reasons why the standards were not met (authority can be delegated), and the respective Military Service headquarters must be notified no later than one week after the MH member takes occupancy.

1 - For purposes of this provision, "serious physical disability" means**:** (a) any physiological disorder or condition or anatomical loss affecting one or more body systems which has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 contiguous months, and

which precludes the person with the disorder, condition or anatomical loss from unaided performance of at least one of the following major life activities**:** breathing, cognition, hearing, seeing, and age appropriate ability essential to bathing, dressing, eating, grooming, speaking, stair use, toilet use, transferring, and walking; or (b) serious psychological disabilities, such as post-traumatic stress disorder. (This definition is based primarily on 32 C.F.R. 199.2, the regulations for the CHAMPUS/TRICARE program.)

2 - For purposes of this provision, "direct result of armed conflict" means there was a definite causal relationship between the armed conflict and the resulting unfitting disability. The fact that a member may have incurred a disability during a period of war or in an area of armed conflict or while participating in combat operations is not sufficient to support this finding. Armed conflict includes a war, expedition, occupation of an area or territory, battle, skirmish, raid, invasion, rebellion, insurrection, guerrilla action, riot, or any other action in which Service members are engaged with a hostile or belligerent nation, faction, force, or terrorists. Armed conflict may also include such situations as incidents involving a member while interned as a prisoner of war or while detained against his or her will in custody of a hostile or belligerent force or while escaping or attempting to escape from such confinement, prisoner of war, or detained status. (This definition is based on DoDI 1332.38, Physical Disability Evaluation, paragraphs E3.P5.2.2.1 and E3.Pfi.1.2.)

6. **ASSIGNMENT**

As a general rule, unless dictated otherwise by special medical requirements, MH personnel shall be assigned/referred to housing that exceeds or meets the applicable quality standards and that**:** (a) is appropriate for their expected duration of their treatment, (b) supports a non-medical attendant, if authorized, (c) supports accompaniment by their dependents when desired and not incompatible with their treatment, and (d) is appropriate for their pay grade (e.g., configuration and size). Note that from a housing assignment/referral perspective, an authorized non-medical attendant shall be treated like a dependant, e.g., if no other acceptable accommodations are available, a single MH member with an authorized non-medical attendant shall be eligible for temporary assignment to family housing. For example, MH personnel (whether single or married) with an authorized non-medical attendant and facing a long rehabilitation period should not be housed in a one-room lodging unit, but instead be provided with a lodging unit with a minimum of two bedrooms with a kitchen and living room (e.g., PCS lodging), or family housing (DoD-owned or privatized). When eligible for DoD-owned housing, MH personnel shall be included as part of "Priority I", as defined by DoDD 4165.63M, DoD Housing Management Manual. This referral priority should also apply to privatized or long-term leased (e.g., section 801) housing or lodging provided the referral is consistent with the privatized project's operating agreement. If appropriate housing is not available on the installation on which the member is receiving care, or at nearby military installations, and the service member does not reside in a privately-owned or rented home, MH personnel should be housed off the installation in private sector accommodations that are appropriate for their expected duration of treatment, dependency status (at their treatment location), and pay grade unless dictated otherwise by special medical requirements.

[redacted]

7. **BASELINE STANDARDS**

Condition

All MH personnel housing must be in good overall condition with no major problems with any of the building systems, i.e., all are working properly and not at risk of imminent failure or malfunction. Building systems include but are not limited to roof, exterior walls, foundation, doors and windows, interior finishes, plumbing, lighting, electrical, life and fire safety, and heating-ventilating-and air-conditioning (HVAC). It is important that MH personnel be able to adequately control the temperature in their housing units. There shall be no mold, exposed lead-based paint, unsealed asbestos, inadequate air circulation, or any other environmental/safety/ health hazard.

Kitchens

Kitchens are an important quality of life feature for MH personnel who face long rehabilitation periods, especially those with authorized non-medical attendants. Accordingly, kitchens shall be provided that exceed or meet existing applicable standards for the type of accommodations provided (unaccompanied housing, lodging, or family housing).

Laundry Facilities

Laundry facilities shall be provided as defined by the type of housing (unaccompanied personnel housing, lodging, or family housing), or as applicable based on medical condition. If an assigned/referred housing unit only has laundry equipment hook-ups, a residential-quality clothes washer and a dryer should be provided as loaned furnishings.

Furnishings

Provide loaned furnishings as appropriate.

Electronic Equipment

Generally, a television with cable/satellite service, internet service, and a telephone with local service shall be provided in each MH member's housing unit. If a MH member is unable to bring their personal electronic equipment to their assigned/referred housing, and they face a long rehabilitation period, efforts should be made to provide additional electronic devices such as a VCR/DVD player, stereo, computer with printer, and video game player. If the internet service is hard-wired, consideration should also be given to providing WiFi and a laptop computer.

Housekeeping and Pest Management

MH personnel housing shall be kept free of pests and litter, and trash containers shall be emptied on an appropriate cycle.

Landscaping, Grounds Maintenance, and Parking

Parking areas, turf, and grounds shall be well-maintained, attractive and litter-free. The number of parking spaces shall be adequate to support expected occupancy. Snow and ice shall be removed promptly from walkways and parking areas to ensure safety and prevent injuries.

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Physical Security
MH member accommodations shall be provided with appropriate physical security measures, including required lighting levels inside and outside (parking and walkways).

Building Maintenance and Housekeeping Requests
An effective preventative maintenance program shall be in place for MH personnel housing. Also, installations shall have a mechanism where MH personnel can request building maintenance and housekeeping services.

8. **SPECIAL MEDICAL REQUIREMENTS**

Many MH members will have certain medical conditions that result in various functional limitations. For these members, it is essential that special accommodations and services be provided as an integral part of their medical treatment plan as determined by the primary care physician, patient, and chain of command. Some of these limitations will be permanent, but many others will change during recovery and rehabilitation, which may eliminate the need for certain special accommodations or services.

Accessibility
For members who have accessibility requirements, accommodations must, at a minimum, comply with the most current standards issued by the Department of Defense under the Architectural Barriers Act of 1968, as amended. Note that accessibility also applies to the route and distance (e.g., walkways, ramps, parking) that a MH member must travel from their housing accommodations to reach their medical treatment center, dining facility, or other support services. For all other MH member accommodations, consideration should be given to incorporating "universal design" principles (e.g., lever type door handles in lieu of knobs).

Cognition
When required, MH member accommodations shall address the range of cognitive limitations that result from conditions such as Traumatic Brain Injury (TBI), Post Traumatic Stress Disorder (PTSD), and stroke. For example, sometimes complex geometric patterns on rugs, linens, or flooring can cause disorientation in these patients. Flooring and carpet with a subtle texture or pattern often helps with depth perception.

Visual and Auditory
Necessary features for visually and auditorily impaired MH personnel shall be provided in accordance with the DoD standards.

Burns
MH personnel recovering from serious burns or nerve/neurological injuries are very sensitive to hot water, so consideration shall be given to installing special devices to regulate the water temperature.

Other Physical Limitations
Standard accessibility guidelines generally are adequate for ambulatory impaired MH personnel except in special cases such as when they are in a wheelchair with one or both legs in an

[redacted]

extended position. In this case, normal wheelchair clearances and turning circles may be inadequate. Even with the loss of both legs, MH personnel can be fully ambulatory with their prostheses, but still need accessible accommodations when they are in a wheelchair (such as when they have to use the bathroom at night). For physically impaired MH personnel, bathrooms are the major source of concern. Suggestions for improvement include doors that open to the outside, additional clearance for wheelchairs, and longer hoses on shower nozzles. For MH personnel with loss of or injury to arms and hands, accommodations shall be provided with either a bidet bowl or an electrically powered 'add-on bidet' that replaces a normal toilet seat to rinse the peritoneal area.

Housekeeping

If a MH member without a non-medical attendant would have difficulty with basic housekeeping, it may be necessary to assign them to housing where these services are included with the accommodations, such as lodging, or to provide the required services for their housing unit such as by contract. Provide disposal of bio-hazard waste as required.

Laundry Services and Equipment

Special laundry service may also have to be provided for MH personnel who have a medical condition that requires their linens, towels, and clothing to be disinfected. In accessible units with a laundry, the clothes washer and dryer should be accessible from a wheelchair.

Kitchens and Food service

For certain medical conditions, a kitchen or kitchenette may be prescribed, either in the unit or located within the same building. On the other hand, there could be special dietary requirements that would be most effectively handled by a hospital or installation dining facility. Note that ranges and cook tops in accessible units shall have control knobs on the front for easy wheelchair access.

Furnishings

Accessible rooms need to have accessible furnishings, such as computer desks and higher beds.

Parking

MH personnel with mobility impairments shall have first priority in assignment and use of all parking spaces under the control of the facility, beginning with those spaces closest to the entrances and exits used by MH personnel. The next level of priority shall be extended to individuals who transport MH personnel with these types of disabilities. If possible, spaces shall be provided for pickup and drop-off in addition to daily and overnight use. The number of spaces shall be adequate to support the expected occupancy, including the required number of accessible spaces. Additional spaces shall be provided on an expedited basis to meet unforeseen needs.

Proximity to Outpatient Treatment Center and Other Services

MH personnel may require housing in close proximity to a medical treatment facility for reasons related to their disabilities or medical conditions. For example, there may be a substantial risk of unanticipated urgent medical situations that require prompt attention by caregivers, or the frequency and duration of routine medical treatment may dictate the need for housing nearby. Transportation must be provided for MH personnel who do not have their own means of

[redacted]

transport (e.g., transportation by a non-medical attendant with a POV) and who are not housed adjacent to their outpatient medical treatment facilities (whether on or off the installation). This transportation must be adequate to ensure timely access to treatment, dining facilities, and other important support facilities such as exchanges and commissaries.

9. **INSPECTIONS**

The Military Services shall conduct periodic inspections of MH personnel housing in accordance with these standards, at least on an annual basis. Inspections of privatized housing and lodging containing MH personnel shall be accomplished only with prior coordination with the project partner or owner. In the event a deficiency is identified, the commander of such facility shall submit to the Secretary of the Military Department a detailed plan to correct the deficiency; and the commander shall re-inspect such facility not less often than once every 180 days until the deficiency is corrected.

10. **FEEDBACK AND UPDATES**

The Military Services shall implement periodic and comprehensive follow-up programs using surveys, one-on-one interviews, focus groups, and town-hall meetings to learn how to improve MH personnel housing and related amenities/services. Such feedback should be solicited from the MH members, their families and friends, care-givers, chain of command, and housing owners/operators. Summaries of the feedback with resulting changes should be provided on a periodic basis to OSD, in conjunction with any other reporting requirements.

11. **IMPLEMENTATION**

The Military Departments have the authority to issue supplemental instructions to provide for unique requirements within their respective organizations provided they conform to the basic policy guidance in this document.

[redacted]

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Appendix 3 Acronym List

ABA	Architectural Barriers Act
ADA	American Disabilities Act
ALARACT	All Army Activities
CFR	Code of Federal Regulation
DEPSECDEF	Deputy Secretary of Defense
DoD	Department of Defense
DPW	Directorate of Public Works
GFCI	Ground Fault Circuit Interrupter
HIPAA	Health Insurance Portability and Accountability Act
HVAC	Heating, Ventilation, and Air Conditioning
IAW	In accordance with
IG	Inspector General
IM	Information Management
IMCOM	Installation Management Command
MEDCOM	US Army Medical Command
MH	Medical Hold
MSDS	Material Safety Data Sheets
NFPA	National Fire Protection Association
NRMC	Northern Regional Medical Command
PHI	Protected Health Information
PII	Personally Identifiable Information
PTSD	Post Traumatic Stress Disorder
RMC	Regional Medical Command
SMC	Senior Mission Commander
SME	Subject Matter Expert
SOP	Standard Operating Procedures
TBI	Traumatic Brain Injury
UPH	Unaccompanied Personnel Housing
WT	Warrior in Transition
WTB	Warrior Transition Brigade
WTU	Warriors in Transition Unit

[redacted]

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Appendix 4 References

ALARACT 295/2008, 9 December 08, Subject**:** MOD 1 to ALARACT 162/2008

ALARACT 162/2008, 3 July 2008, Subject**:** Inspection of Armed Forces Facilities Used to House Recovering Service Members Assigned to Army Warrior Transition Units

Army Regulation 420-1, Army Facilities Management, 12 February 2008

National Defense Authorization Act (NDAA), Public Law 110-181, Sec 1662, 28 January 2008, Subject: Access of Recovering Service Members to Adequate Outpatient Residential Facilities

Memorandum, Deputy Secretary of Defense, 18 September 2007, Subject: DoD Housing Inspection Standards for Medical Hold and Holdover Personnel

Memorandum, Deputy Chief of Staff, G-1, HQDA, 18 June 2007, Subject: Housing Prioritization for Warriors in Transition

Memorandum, Assistant Chief of Staff for Installation Management (IMCOM), 14 October 2009, Subject: Unaccompanied Personnel Housing (UPH) for Warriors in Transition

Army Regulation 190-11, Physical Security of Arms, Ammunition, and Explosives, 15 Nov 06

29 CFR 1910.304, Occupational Safety & Health Administration

National Fire Protection Association

[redacted]

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